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No. 88-1546

IN THE
Supreme Court of the United States
OCTOBER TERM, 1988

PACIFIC MUTUAL LIFE INSURANCE COMPANY, *et al.*,
Petitioners,

v.

HARRIETTE TURNBOW,
Respondent.

On Petition for Writ of Certiorari to the Supreme Court of Nevada

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* OF UNUM LIFE INSURANCE CO. IN SUPPORT OF PETITIONER

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April 19, 1989

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MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE*

UNUM Life Insurance Company ("UNUM") hereby respectfully moves for leave to file the attached brief *amicus curiae*. The attorney for petitioners has consented; the attorney for respondent has refused consent.

UNUM and its affiliates [1] sell and service employee welfare benefit plan insurance in all 50 states and the District of Columbia, and insure more employer-sponsored long term disability plans (over 25,000) with a greater number of insured employee participants (2,919,872) [2] than any other insurer in the United States.[3] UNUM also insures over 8,000 group-employer sponsored life and

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[1] UNUM Life Insurance Company of America and First UNUM Life Insurance Company of New York, formerly known as Union Mutual Stock Life Insurance Co. of America and Unionmutual Stock Life Insurance Co. of New York, respectively.

[2] As of December 31, 1988.

[3] *Employee Benefits Plan Review*, April, 1987.

health insurance plans. UNUM group policies insure 3,102 employer-established and maintained benefit plans issued through 29 multiple employer trusts ("METs"), which make insured benefits available to employees of small employers at lower, affordable rates.

The questions presented in the instant case are of great importance to UNUM and to every other insurer that issues insurance to employee welfare plans. As an ERISA claims fiduciary for many of the employee welfare benefit plans it insures nationwide, UNUM's claim practices with respect to its employee benefit plan insurance are subject to federal regulation under ERISA.

The decision of the Nevada Supreme Court will have substantial adverse consequences for UNUM, other insurers of employee welfare plans, multi-employer trusts and other instrumentalities providing coverage for employee welfare plans, as well as for ERISA plan participants and beneficiaries. Because of its extensive experience and involvement with ERISA plans, UNUM is uniquely situated to advise the Court of the far-reaching consequences of the Nevada Supreme Court's decision in this case.

For the foregoing reasons, UNUM Life Insurance Co. respectfully urges the Court to accept and file the enclosed brief *amicus curiae*.

Respectfully submitted,

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Dated: April 19, 1989

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BRIEF *AMICUS CURIAE* OF UNUM LIFE INSURANCE COMPANY

INTEREST OF *AMICUS*

The interest of *amicus* UNUM Life Insurance Co. is set forth in the accompanying motion for leave to file brief *amicus curiae*.

INTRODUCTION AND SUMMARY OF ARGUMENT

In *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), this Court made clear that Congress intended all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated health insurance plans to be treated as federal questions governed by § 502(a), 29 U.S.C. § 1132(a).[1] Congress and the Court expected that a federal common law of rights and obligations under ERISA-regulated plans

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[1] 481 U.S. at 56.

would develop.[2] Congress' intent was manifest in the broad pre-emptive provisions it included in ERISA.

In *Pilot Life* as in other pre-emption cases resolved by this Court,[3] there was no doubt that the defendant plan and the plaintiff participant or beneficiary were subject to ERISA. The cases instead concerned various consequences that flowed from ERISA coverage. In each of these cases, the Court recognized the broad sweep Congress intended to give federal principles in the area of employee benefits.

In this case an insured covered by employer-provided group health insurance sought to persuade a court that she is entitled to pursue state law remedies, including punitive damages, in a suit against her insurer for improper administration of her insurance coverage. She could no longer assert that her right to state law remedies survives within ERISA—that legal claim was effectively foreclosed by this Court's decision in *Pilot Life*. Instead, the plaintiff urged two even more fundamental objections to ERISA pre-emption of her state law claims: (1) that her employer-funded group insurance was not an "employee welfare benefit plan" as that phrase is used in ERISA, because the plan documents lack "some indication that [the] employer is committed to or has guaranteed the continuation of such benefits" (Cert. Pet. at 4a); and (2) that as the owner-operator of her unincorporated business, she was not a plan "participant" as that term is used in ERISA, and so not subject to the statute. The Nevada Supreme Court, reversing the deci-

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[2] *Id.*

[3] *E.g., Mackey v. Lanier Collections Agency & Service, Inc.*, —— U.S. ——, 108 S. Ct. 2182 (1988); *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987); *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 (1985); *Alessi v. Raybestos—Manhattan, Inc.*, 451 U.S. 504 (1981); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983).

sion of the trial court, accepted both of the claimant's arguments.

In *Pilot Life* this Court stressed the importance Congress placed on uniformity of standards in all aspects of group employee health and welfare insurance provided through employee benefit plans. The centerpiece of Congress' plan to achieve such uniformity was the preemption provisions of ERISA. The Nevada Supreme Court has undermined this Congressional plan by creating unique standards for determining what is a plan and who is a plan beneficiary. As a result, the federal interest in uniform application of the law has been thwarted. Point I(A).

In particular, the Nevada Supreme Court has imposed a "guarantee of continued benefits" standard that is a required feature of employee *pension* plans, but has not heretofore been considered a requirement of employee health and welfare plans. This requirement is not found in the words of ERISA, or in the Department of Labor regulations interpreting the statute. The legitimacy of this new requirement raises an important issue of federal law requiring the review of this Court. Point I(B).

The Nevada Supreme Court has held alternately that a self-employed owner-operator who is listed in the plan as a beneficiary along with her employees is not a plan participant covered by ERISA. In so ruling, the court rejected the Department of Labor's understanding of the status of such owner-operators. As a result of the court's ruling, owner-operators have all of the benefits of ERISA as a result of plan and insurer compliance with Department of Labor regulations, while those providing the plan benefits gain none of the certainty and uniformity envisioned by ERISA's sponsors and lose the statute's preemption of state causes of action. Congress could not have intended such an anomalous result, and only this Court can resolve this inconsistency. This Court there-

fore should review this important question of federal law. Point I(C).

The decision of the Nevada Supreme Court is in conflict with the decisions of four United States Courts of Appeals, and involves an area of ERISA law that is in a state of general confusion. This Court should review this matter to resolve this conflict. Point II(A).

Inconsistent understanding of crucial underlying ERISA concepts such as the definition of a "plan" and a "participant" strike at the heart of the uniform administration of employee benefit plans. Nevada's definition of "plan," moreover, invites employers to attempt to avoid ERISA compliance. Clarification of these central statutory terms is urgently needed. Point II(B).

ARGUMENT

I. THIS COURT SHOULD GRANT CERTIORARI TO DETERMINE WHETHER A GROUP EMPLOYEE WELFARE BENEFIT PLAN IS SUBJECT TO ERISA WHETHER OR NOT THE EMPLOYER HAS INDEFINITELY "GUARANTEED" THE CONTINUATION OF HEALTH INSURANCE BENEFITS.

A. Congress Intended That Employee Benefit Plans Be Governed Exclusively By A Uniform Body Of Federal Law.

In *Pilot Life* this Court observed that ERISA protects "participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and their beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to Federal courts." [4] The legal issues raised by the decision of the Nevada Supreme Court have national importance be-

[4] 481 U.S. at 44, *citing* 29 U.S.C. § 1001(b).

cause the effect of the decision is to deny ERISA protection to a large population of beneficiaries heretofore covered in Nevada, while similarly situated beneficiaries across the rest of the Nation remain covered.

Two years ago this Court announced in *Pilot Life* that ERISA comprehensively regulates employee benefit plans which, through the purchase of insurance or otherwise, provide medical, surgical or hospital care, or benefits in the event of sickness, accident, disability or death.[5] The pre-emption provisions of ERISA, the Court observed, are deliberately expansive and designed to establish plan regulation as exclusively a federal concern.[6] The Court placed significant reliance on the fact that the House and Senate sponsors emphasized both the breadth and importance of ERISA's pre-emption provisions.[7]

Congress' intent was to federalize the regulation of *all* employee benefit plans in order to eliminate the threat of conflicting or inconsistent regulation of such plans and create a uniform body of Federal law.[8] In *Pilot Life*,

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[5] 481 U.S. at 44.

[6] 481 U.S. at 46.

[7] *Id.* The Court noted the centrality of Representative Dent's description of the "reservation to Federal authority the sole power to regulate the field of employee benefit plans as ERISA's crowning achievement" and Senator Williams' explanation that the Act intended to pre-empt the field in order to eliminate the threat of conflicting or inconsistent State and local regulation of employee benefit plans, which principle was intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof which have the force or effect of law. *Id.*

[8] The underlying purpose of pre-emption is to eliminate the threat of conflicting and inconsistent state and local regulation. Federal pre-emption avoids this result by ensuring that the administration of an employee benefit plan will be governed by a single set of federal laws. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987).

the Court concluded that Congress made clear its intention that all suits brought by beneficiaries or participants under ERISA-regulated plans must be treated as federal questions governed by ERISA, and that Congress expected a federal common law of rights and obligations under ERISA plans would develop.[9]

Notwithstanding the Court's ruling in *Pilot Life*, the Nevada Supreme Court ruled that state law remedies were available to a beneficiary of an employee benefit plan claiming improper administration of insurance coverage—the exact claim this Court ruled in *Pilot Life* was pre-empted.[10] It did so by recognizing two novel limitations on the definition of an ERISA plan, and an ERISA plan participant. The ruling at issue, while favoring the beneficiary here, if allowed to stand will cause great harm and mischief to Nevada plan participants and beneficiaries. It also subjects *amicus* and other insurers offering group health insurance to employer-sponsored plans to conflicting standards: the same claim dispute in Nevada will be treated as governed by Nevada law, while in other States it will be subject to ERISA remedies and ERISA preemption. The Nevada opinion therefore raises important questions of federal law. No Court other than this one can resolve the inconsistent application of ERISA caused by the Nevada decision. Review by this Court is therefore urgently needed.

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[9] 481 U.S. at 56.

[10] In this case the Nevada Supreme Court reversed a trial court decision which, on the basis of ERISA's pre-emption of state law remedies for the mishandling of insurance claims, granted summary judgment against plaintiff (Cert. Pet. at 6a-7a). The Nevada Supreme Court remanded the case for plaintiff to proceed to trial on all her insurance bad faith causes of action (Cert. Pet. at 5a).

B. The Nevada Supreme Court Created A Novel Requirement That For A Plan To Be Governed By ERISA The Employer Must Guarantee The Continuation Of Employee Welfare Benefits. The Legitimacy Of This New Requirement Raises An Important Question Of Federal Law Requiring Review.

ERISA defines "employee welfare benefit plan" to mean (insofar as relevant here):

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer . . . to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment. . . .

ERISA § 3(1), 29 U.S.C. § 1002(1). Parsing the language of this statutory definition, federal courts of appeals have established a five element test to determine whether insurance benefits are subject to ERISA. To be an ERISA plan, there must be: (1) a plan, fund or program, (2) established or maintained, (3) by an employer or by an employee organization, or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, or other benefits not relevant here, (5) to participants or their beneficiaries. *Kanne v. Connecticut General Life Insurance Co.*, 859 F.2d 96, 98 (9th Cir. 1988); *Ed Miniat, Inc. v. Globe Life Insurance Group, Inc.*, 805 F.2d 732, 738 (7th Cir. 1986), *cert. denied*, 482 U.S. 915 (1987); *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) (en banc). *Accord, Dodd v. John Hancock Mutual Life Insurance Co.*, 688 F. Supp. 564, 566-67 (E.D. Cal. 1988).

In recognition of the broad reach of ERISA coverage, the Department of Labor has promulgated regulations that narrowly define those few employee group health

benefit arrangements that are *not* "employee welfare benefit plans." With respect to plans funded by group insurance, the regulations exclude from ERISA coverage only those group insurance programs offered by an insurer to employees which meet each of the following criteria: (1) the employer makes no contributions; (2) participation in the program is completely voluntary for employees; (3) the sole functions of the employer with respect to the program are, without endorsing the program, to permit the insured to publicize the program to employees, to collect premiums through payroll deductions and to remit them to the insurer; and (4) the employer receives no consideration in connection with the program, other than reasonable compensation for administrative services actually rendered in connection with the payroll deductions. 29 C.F.R. § 2510.3-1(j) (1988). In these limited circumstances, an employer may be involved in a welfare plan without "establishing" or "maintaining" it. Until the decision in the instant case, most courts have held that a plan is included under ERISA coverage unless all four of these regulatory criteria are met. *See, e.g., Shiffler v. Equitable Life Assurance Soc.*, 663 F. Supp. 155, 160-61 (E.D. Pa. 1986), *aff'd*, 838 F.2d 78, 82 n.4 (3d Cir. 1988); *Kanne*, 859 F.2d at 99.

The welfare plan below did not meet all four of the requirements the DOL has set for non-ERISA plans. Indeed, the plan did not meet even one of these requirements.[11] The Nevada Supreme Court did not find to the

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[11] The record in this case, unquestioned by the Nevada Supreme Court, established that plaintiff was the owner of a business known as "The Bottle Stop" (Cert. Pet. at 1a-2a); that in 1974 "The Bottle Stop" subscribed to Beneficial Employees Security Trust's American Series Plan to procure health care benefits, including major medical benefits of up to $1,000,000 for herself and her full-time employees (Cert. Pet. at 3-4, 1a-2a); that the plan specified that partners or owners were considered "employees" for purposes of the plan if they worked 30 hours or more per week (Cert. Pet. at 3-4); that plaintiff, who managed the business and worked in it

contrary, but nevertheless determined that it was not an ERISA plan because it failed to meet a requirement created out of whole cloth by the court: that ERISA plans provide "some indication that an employer is committed to or has guaranteed the continuation of . . . benefits." Cert. Pet. at 4a.[12]

The legitimacy of this new requirement identified by the Nevada Supreme Court raises an important question of Federal law. If the court is correct, then many if not most plans now thought to be subject to ERISA are in fact *not* ERISA plans. Indeed, *no* welfare plans of which *amicus* is aware make any such guarantee of continuing benefits.

There is, to be sure, a commonly recognized "guarantee of continued benefits" requirement *elsewhere* in ERISA. Congress in enacting ERISA believed it was important that employers be required to guarantee the continuation of *pension* benefits—and so established detailed vesting requirements to ensure that employees' continued benefits be guaranteed.[13] The Nevada court has understood

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along with three other employees, had coverage and received her benefits under the plan through May, 1983, when it was terminated, and also received the one year extension of benefits provided thereafter (Cert. Pet. at 4-5, 2a).

[12] Apparently, The Bottle Stop's continuous maintenance of the program, annual filings on its behalf with DOL, and payment of premiums for period of over eight years (*see* Cert. Pet. at 3-4, 1a-2a) did not constitute such an indication of commitment to the court below.

[13] *See* ERISA § 203(a), 29 U.S.C. § 1053(a); 29 C.F.R. § 2530.203-1. Those standards effectively require the continuation of pension plans with respect to employees holding vested rights. However, Congress opted for less comprehensive vesting rules in order to strike a balance "between providing meaningful reform and keeping costs within reasonable limits." S. Rep. No. 383, 93d Cong., 2d Sess. 18, *reprinted in* 1974 U.S. Code Cong. & Admin. News 4890, 4904. Congress' election *not* to mandate any vesting or continuity requirements for welfare plans must be regarded as a conscious choice not to require a guarantee of continuation of such plans, unlike pension plans.

ERISA to impose the same requirements on *health and welfare* benefits—if they are to be considered "plans" subject to ERISA. This ruling could disqualify virtually every Nevada employee welfare plan [14] now reporting to the Secretary of Labor.[15] No other court has imposed such a requirement on health and welfare plans. Plainly, Congress intended no such requirement to be imposed on such plans. The Nevada court's opinion is so evidently incorrect that a summary reversal might well be appropriate. At the least, the Court should grant plenary review to address this important question of Federal law and ensure national uniformity in the application of ERISA.

C. The Nevada Supreme Court Has Determined That The Owner Of An Unincorporated Business Is Excluded From Coverage As An ERISA Plan Participant, Raising An Important Question Of Federal Law Requiring Review.

As an alternative rationale supporting its decision, the Nevada court ruled that plaintiff could not be considered an ERISA plan "participant" because she was the owner of an unincorporated business. This holding, too, is flatly inconsistent with the Department of Labor regulations governing plan participation. As a result of the court's ruling, many beneficiaries previously treated as protected by ERISA will *not* be covered by the statute in Nevada, while they are covered in all jurisdictions that apply the Department of Labor's regulations. Once again, this alternative holding raises important questions of Federal law that affect the day-to-day operations of a great many employee benefit plans.

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[14] Based upon a survey of trade associations and the Department of Labor by *amicus*, it is estimated that there are now five million employee welfare plans.

[15] *See* 29 C.F.R. §§ 2520.104a-1 to -7 (setting out the Labor Department's reporting and filing requirements).

While ERISA defines "participant" to be "any employee of an employer . . . eligible to receive benefits," 29 U.S.C. § 1002(7), it has long been the understanding of the Department of Labor and the insurance industry that ERISA covers individual proprietors and partners along with their employees, at least when the plan document includes the proprietors.[16] The Department of Labor regulations describe the self-employed as "participants," at least where, as in this case, the plan covers both the self-employed and common law employees.[17]

By failing to accept the DOL's treatment of the self-employed as beneficiaries, the Nevada court has placed insurers in an unfair and unnecessarily confused situation. For virtually all other purposes under ERISA, insurers and plans must treat the self-employed as participants protected by ERISA, entitled to all of the protections the law provides.[18] On the other hand, in Nevada at least, while the self-employed gain all of the benefits that come from ERISA, in suits against insurers they are entitled to bring state law claims and seek state law remedies not governed by ERISA's regulatory scheme and free from the pre-emption clauses of the Act. However Congress intended to treat the self-employed who are beneficiaries of group insurance along with their employees, it certainly did not intend this inconsistent treat-

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[16] *See* N.A.I.C. Group Health Insurance Definition and Group Health Insurance Standard Provisions Model Act, Section 1.

[17] 29 C.F.R. § 2510.3-3(b) (1987). While for some purposes the DOL defines "employee" more narrowly to exclude self-employed individuals, *see* 29 C.F.R. § 2510.3-3, the DOL has made clear in its regulations that this narrow definition of "employee" is to be used only to determine whether a "plan" exists, and is *not* to be used to determine whether a self-employed worker is a participant in a plan. *See* DOL Reporting and Disclosure Regulations, 40 Fed. Reg. 34525, 34528 (August 15, 1975). See also DOL Opinion Letters 79-8A and 81-54A.

[18] *See* cases cited at pages 15-16, *infra*.

ment that has resulted from the Nevada court's ruling. And only this Court is now in a position to remedy this inconsistent application of ERISA created by the Nevada opinion.

Where a plan is funded by the purchase of group insurance, ERISA's goal of uniform treatment of benefit claims is best served when self-employed individuals are also employee participants of the employee welfare benefit plan to which they subscribe. Once again we believe that the Nevada Supreme Court's opinion in this regard is so plainly wrong and so out of harmony with prevailing practice, that a summary reversal would be appropriate. In any event, this Court should at least grant plenary review to assure consistent application of the important federal principles adopted in ERISA.

II. THIS COURT SHOULD GRANT CERTIORARI TO RESOLVE A CONFLICT BETWEEN A STATE COURT OF LAST RESORT AND FOUR UNITED STATES COURTS OF APPEALS ON AN IMPORTANT QUESTION OF FEDERAL LAW.

A. The Nevada Supreme Court Created New Definitional Rules For ERISA Plans That Are Inconsistent With The Rules Applied By The Federal Courts.

The Nevada Supreme Court's disqualification of the plan under review from ERISA coverage creates a clear split between the highest court of a state and four United States Courts of Appeals. The Seventh, Ninth, Tenth and Eleventh Circuits have held that employer adoption of a group insurance plan for its employees creates an ERISA plan, so long as it meets the tests established by the Secretary of Labor. *See Kanne v. Connecticut General Life Insurance Co.*, 859 F.2d 96, 98 (9th Cir. 1988) (plan offered through a MET); *Ed Miniat, Inc. v. Globe Life Insurance Group, Inc.*, 805 F.2d 732, 738 (7th Cir. 1986), *cert. denied*, 482 U.S. 915 (1987); *Roe v. General American Life Insurance Co.*, 712 F.2d 450, 452 (10th Cir.

1983);[19] *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) (en banc) (plan offered through a MET). *Accord*, *Dodd v. John Hancock Mutual Life Insurance Co.*, 688 F. Supp. 564, 566-67 (E.D. Cal. 1988); *Rizzi v. Blue Cross of Southern California*, 253 Cal. Rptr. 541, 543-47 (Cal. Ct. App. 1988). The Nevada decision, in stark contrast, imposes an additional requirement: that the employer guarantee the continuation of benefits. There is no doubt that the plan found *not* to be an ERISA plan by the Nevada court would be considered a plan by each of the courts of appeals to have considered this question.

In addition, the Nevada court's imposition of an additonal "guarantee of continuation" test not contained in the text of ERISA squarely conflicts with holdings by the Federal courts of appeals that the only criteria for finding a covered employee welfare benefit plan are those set out in the five-fold test of *Donovan v. Dillingham*.[20]

The Nevada court, moreover, is not the only court that has imposed additional, non-statutory criteria in order to avoid the pre-emptive effect of ERISA. In *Sayble v. Blue Cross of Southern California*, 255 Cal. Rptr. 144 (Cal. Ct. App. 1989), the California intermediate appellate court held that "the existence of an ERISA plan depends on the extent to which the employer is involved in the administration of the benefit program." *Id.* at 148.[21]

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[19] The *Roe* court explicitly recognized "some split of authority" on this issue. *See* 712 F.2d at 452 (employer sponsored disability program for which employees paid 100% of the disability premium).

[20] 688 F.2d 1367, 1371 (11th Cir. 1982) (en banc). *Accord*, *Kanne v. Connecticut General Life Insurance Co.*, 859 F.2d 96, 98 (9th Cir. 1988); *Ed Miniat, Inc. v. Globe Life Insurance Group, Inc.*, 805 F.2d 732, 738 (7th Cir. 1986), *cert. denied*, 482 U.S. 915 (1987). The five criteria are discussed at p. 7, *supra*.

[21] A petition for rehearing by the intermediate appellate court has been filed in *Sayble* and is now under consideration. The petition notes, among other things, the conflict between the *Sayble*

The court there expressed a concern that, if an employer's payment of premiums were sufficient to constitute a plan governed by ERISA, "every garden variety employee health insurance benefit would subject the paying employer, large or small, to ERISA's regulatory burdens, and would bind the insured employee to ERISA's remedies." *Id.* at 149. Similar concerns led the Fifth Circuit in *Taggart Corp. v. Life & Health Benefits Admin.*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981), to hold that an employee plan financed by insurance purchased through a MET was not an ERISA plan. This older pre-*Pilot Life* Fifth Circuit case, along with the Nevada Supreme Court, hold the view that Congress understood ERISA to be a limited federal enterprise covering only certain plans and certain workers. This Court and most other courts have reached the opposite conclusion.[22]

There is confusion in the courts on the alternative holding of the Nevada Supreme Court. The Seventh Circuit has held that an owner can be an employee and a plan participant under ERISA, *see Ed Miniat*, 805 F.2d at 740 n.14. The Third and Sixth Circuits in an analogous context have held that an employer may have dual status as a fiduciary under ERISA, *U.S. Steel Corp. v. Pennsylvania Human Relations Commission*, 669 F.2d 124, 126-28 (3d Cir. 1982); *Great Lakes Steel v. Deggendorf*,

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decision and that of another intermediate appellate court on indistinguishable facts in *Rizzi, supra.*

[22] There is already pending before the Court one petition for certiorari raising as a question presented the issue of the criteria necessary to establish an ERISA plan. *See Kanne v. Connecticut General Life Ins. Co.*, No. 88-1659, petition for cert. filed April 11, 1989. In the event the Court agrees with *amicus* that this issue should be given plenary consideration, the instant case is a better vehicle for that consideration than the pending petition in *Kanne*. The issue in *Kanne* apparently was not addressed by the trial court, and as a result the record appears to be deficient in relevant ways. Here, on the other hand, the issue was raised and addressed below.

716 F.2d 1101, 1104-05 (6th Cir. 1983). *See also Schwartz v. Gordon*, 761 F.2d 864, 869 (2d Cir. 1985) (Plans which cover both self-employed individuals and their employees governed by ERISA: "when the assets of employees and a self-employed employer are commingled, for example, the only way to assure the needed protection for the former is to protect the latter as well."); *Dodd*, 688 F. Supp. at 570; 29 C.F.R. § 2510.3-3(b).

On the other hand, the Nevada Supreme Court's alternate holding that a self-employed owner is *not* covered by ERISA finds support in a Tenth Circuit decision holding that individuals with dual status as employers and employees were ineligible for inclusion under ERISA, at least where the plan documents expressly excluded as eligible participants self-employed individuals, employers, and owners of contributing business organizations, *Peckham v. Board of Trustees*, 653 F.2d 424, 426-27 (10th Cir. 1981) (*Peckham I*).[23] Trial court decisions are in a similar state of confusion. *Compare Dodd v. John Hancock Mutual Life Insurance Co.*, 688 F. Supp. 564, 571-72 (E.D. Cal. 1988) (the owner of a corporation can be an "employee" and a participant under ERISA); *with Pitre v. Louisiana Health Service and Indemnity Co.*, 122 F.R.D. 497, 500 (W.D. La. 1988) (ERISA is inapplicable to the claim of a partner in a law firm). *See also, Peckham v. Board of Trustees*, 724 F.2d 100 (10th Cir. 1983) (*Peckham II*) (employers named in plan as participants *may* invoke ERISA jurisdiction to sue for restitution of contributions) (appeal following remand in 653 F.2d 424, *supra*); *Chase v. Trustees of Western Conference of Teamsters Pension Trust Fund*, 753 F.2d 744, 748-49 (9th Cir. 1985) (owning drivers of taxicabs should be considered "participants" for purpose of seeking restitution of plan contributions); *Giardono v. Jones*, 867 F.2d 409, 411-12 (7th Cir. 1989)

[23] Here, of course, the plan documents expressly named plaintiff Turnbow as an eligible participant. Cert. Pet. at 4.

(sole proprietor who only employed non-union employees and who therefore was only subscriber to union sponsored health care plan was not an ERISA "participant"); *Taggart*, 617 F.2d 1208 (no ERISA plan is established where a corporation simply buys insurance for its sole employee/owner). Review of the decision below is necessary to resolve the conflict and confusion evidenced by these disparate decisions.

B. The *Turnbow* Decision Creates The Very Patchwork Of Inconsistent State Regulation ERISA Was Enacted To Avoid.

The confusion among the state and Federal courts on these issues is undermining one of the primary goals Congress sought to accomplish in enacting ERISA. A major thrust of the program was to promote uniformity and eliminate the patchwork of inconsistent state and local regulation that plagued private employee benefit plans in the American economy, and retarded the development and the growth of private health insurance. "A virtually unanimous Congress enacted ERISA in order to encourage the establishment and growth of private" employer benefit plans. *Rettig v. Pension Benefit Guaranty Corp.*, 744 F.2d 133, 135 (D.C. Cir. 1984) (footnote omitted).[24]

ERISA's integrated federal scheme for employee benefits, along with its pre-emption of state law and remedies, serves to ensure uniformity in application of the Act's standards to employee welfare plans. Congress acted to promote the "uniformity of decision" necessary

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[24] *See also A-T-O, Inc. v. Pension Benefit Guaranty Corp.*, 634 F.2d 1013, 1021 (6th Cir. 1980); *Michigan United Food and Commercial Workers Unions v. Baerwaldt*, 572 F. Supp. 943, 949 (E.D. Mich. 1983), *rev'd on other grounds*, 767 F.2d 308 (6th Cir. 1985), *cert. denied*, 474 U.S. 1059 (1986) ("Implicit in the whole purpose of the Act is a desire to encourage private pension and welfare plans by promulgating uniform, reasonable, and non-oppressive federal requirements.")

for "administrators, fiduciaries and participants to predict the legality of proposed actions." S. Rep. No. 127, 93d Cong., 2d Sess. ——, *reprinted in* 1974 U.S. Code Cong. & Admin. News 4838, 4865.[25]

By permitting plan administrators, employers and beneficiaries reasonably to expect a measure of consistency in implementation of welfare plans among varied locations and in varied circumstances, the Act provides the predictability central to effective implementation of a private system of employee welfare.

The lesson of the *Turnbow* decision is that in Nevada an employee welfare plan, to qualify as an ERISA plan, must have an employer's "statement of intent to guarantee the continued furnishing of benefits" (Cert. Pet. at 4a), whereas plans in other states will remain subject to ERISA in the absence of such a requirement and participants and beneficiaries under the plans will continue to enjoy ERISA's protections. The Nevada court's decision is moreover an open invitation to employers to opt out of ERISA and its mandatory Federal requirements by announcing that they will not guarantee the continuity of benefits. As such, the decision is in considerable tension with the many court decisions that have held that Congress did not intend to allow employers offering benefit plans to "opt out" of ERISA coverage by failing to adhere to its filing and notice requirements.[26] Of

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[25] *E.g., Holland v. Burlington Industries*, 772 F.2d 1140, 1147 (4th Cir. 1985) (Congress' "major policy objective" was "*uniformity* in employee benefit laws") (emphasis in original), *aff'd mem. sub nom. Brooks v. Burlington Industries*, 477 U.S. 901 (1986); *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1501 (9th Cir. 1985), *citing Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *see also* 120 Cong. Rec. 29,197 (1974) (statement by Rep. Dent); 120 Cong. Rec. 29,933 (1974) (statement by Sen. Williams).

[26] *See, e.g., Blau v. Del Monte*, 748 F.2d 1348, 1355 (9th Cir. 1984), as amended March 5, 1985, *cert. denied*, 474 U.S. 865 (1985); *Donovan v. Dillingham*, 688 F.2d at 1372.

course, only in Nevada may an employer "opt out" of ERISA. Similarly, in Nevada a self-employed operator of a business can never be an ERISA plan participant; if she crosses over to California [27] she is covered by ERISA. This is the very patchwork of regulation Congress sought to eliminate.

CONCLUSION

For the foregoing reasons, *amicus* urges this Court to grant the petition for certiorari.

Respectfully submitted,

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[27] *See Rizzi*, 253 Cal. Rptr. at 543-47.